6 Receiving Reimbursement

This chapter describes the Explanation of Payment (EOP) report and the reimbursement schedule for Medicaid fee-for-service claims.

NOTE:

Reimbursement information specific to managed care is described in Chapter 39, Patient 1st, of this manual.

6.1 Explanation of Payment (EOP) Report

It is the responsibility of each provider to follow up on claims submitted to EDS. The Explanation of Payment (EOP) is a vital tool for this process. The EOP indicates claims that have been adjudicated (paid or denied) and lists claims that are currently in process (suspended claims). Providers are urged to examine each EOP carefully and to maintain the document for future reference. Claims listed as claims in process are being processed and will appear on one of the next two EOPs as paid, denied, or still in process.

A provider has the choice of receiving an electronic copy of the EOP, in addition to the paper copy. The electronic copy is the 835 Health Care Claim Payment/Advice. Both the paper and the electronic media have been expanded to include more information. Providers wishing to receive the 835 must be assigned a 'submitter ID" and an indicator must be set in the system to generate the electronic report*. The Electronic Explanation of Payment Agreement Form is available on the Alabama Medicaid website.*

The EOB (Explanation of Benefit) code that displays next to a paid or denied claim explains the adjudication of the claim. A provider who wishes to question a paid or denied claim should do so by calling the EDS Provider Assistance Center at 1(800) 688-7989. To request an adjustment of a previously paid claim, refer to Section 5.8, Adjustments, for more information.

Any claim that does not appear on an EOP within forty-five working days from the time of submission should be resubmitted immediately. Before resubmitting, please verify that the claim has not been returned to you for correction or additional information.

Providers are required to maintain a copy of each claim submitted. The claim copies should be used for comparison if there are questions concerning the disposition of claims as shown on the EOP.

6.1.1 Provider Explanation of Payment (EOP)

Twice a month, providers are issued a single remittance check or Electronic Funds Transfer (EFT) transaction for all claims that have been processed for payment for that checkwrite's pay period. Providers who choose to have their payments deposited directly to their bank receive their Explanation of

Payment (EOP) a few days earlier than providers who receive a paper check. Paper checks are generated and mailed to providers with the EOP.

The EOP displays the paid or denied status of adjudicated (settled) claims, as well as lists claims currently in process, claims credited to the Medicaid Agency, and any refunds that are processed. The sections of the EOP are described in the following paragraphs.

Each page displays the payee provider's submitter ID, name, address, and Medicaid provider number printed as it currently appears on EDS' provider file. The EOP number and checkwrite date display on each page of the EOP as well.

The columns that display at the top of every page correspond to the information in the sections that list paid and denied claims.

SUBMITTER ID
STATE OF ALABAMA

MEDICAL ASSISTANCE EXPLANATION OF PAYMENT
ALABAMA MEDICAID INFORMATION SYSTEM
EXPLANATION OF PAYMENT

Anywhere Physicians Clinic
123 Main St.
Anywhere, USA 12345

PROVIDER NUMBER **520000000** CNTRL NUM 000000 REPORT SEQ NUMBER 4 EOP
NUMBER 0000000 DATE 01/01/2000 PAGE 1

NAME RECIPIENT ID	SERVICE DATES FROM MM DD YY	TO MM DD YY	DAYS OR UNITS	PROC/ REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PATIENT LIABILITY	DEDUCTED AMOUNTS	OTHER DEDUCTED AMOUNTS	PAID AMOUNTS

First Page

A "Mini-Message" from EDS appears on this page. The "Mini-Message" delivers information to the provider community and includes updates to current policies and procedures.

NOTE:

A single EOP issued for several providers (such as for a corporation or a group) lists each provider number in the group separately in numeric order.

Paid Claims

This section of the EOP lists a payment for each claim in alphabetical order by recipient last name.

Claims are grouped by claim type, with a total for each. A grand total of paid claims and paid amounts displays at the end of this section.

Paid claims may include an EOB code to provide more information about the payment amount. For example, a provider may bill an amount higher than Medicaid allows for a procedure. The EOB code next to this paid claim explains why the provider received a lower payment than he submitted.

The following table lists the fields in the paid claims section from left to right, top to bottom. Not all paid claims will display data in every field.

Note: The fields listed in the following tables are based on information available at the time of publication. The information is subject to change based on further review.

Field	*Description*
Recipient Name	Displays the recipient's last name, first name, and middle initial. Claims are displayed in alphabetical order by last name.
PCN	Displays the Patient Control Number assigned to the recipient by the provider. This is the patient account number.
RCC	This field is no longer populated.
ICN	Displays the internal control number of the claim. Use this number when inquiring about the claim.
MRN	Displays the Medical Record Number assigned to the recipient by the provider.
Perf Phys	Displays the provider number of the performing provider.
Recipient Medicaid ID	Displays the 13 digit recipient Medicaid ID number.
First date of service - last date of service	Displays the dates of service submitted on the claims in MMDDYY format. This displays for each line item billed, if applicable.
Procedure/Revenue/ Drug Code and Description	Displays these codes as they were submitted on the claim, with a description of the procedure code. This displays for each line item billed, if applicable. Effective on the first Checkwrite in October 2003 the following fields will no longer display on the EOP: Place of Service and Type of Service.
Total Billed	Displays the amount billed on the claim. This displays for each line item billed, if applicable.
Non Allowed	Displays the amount of the billed amount that Medicaid will not cover. This displays for each line item billed, if applicable.
Total Allowed	Displays the amount of the billed amount that Medicaid will cover. This displays for each line item billed, if applicable.
Patient Liability	Effective on the first Checkwrite in October 2003 this field will no longer be populated on the EOP.
Other Deducted Charges	Displays the amount paid by a third party insurance. This displays for each line item billed, if applicable.
Paid Amount	Displays the amount Medicaid paid the provider for the claim. This displays for each line item billed, if applicable.
ARC/RRC Codes	Displays an Adjustment Reason Code and or a Remittance Remarks Code about claim adjudication. This displays for each line item billed, if applicable.
DED	This field is only used for adjusted claims.
TPL	Displays the amount paid by a third party insurance.
Total Billed	Displays the total billed for all line items on the claim.
Total Non Allowed	Displays the total payment that Medicaid will not cover for all line items on the claim.

Field	*Description*
Total Allowed	Displays the total allowed amount for all line items on the claim.
Total Patient Liability	Displays the total patient liability for all line items on the claim.
Total other deductible charges	Displays the total deductible charges for all line items on the claim.
Total Paid Amount	Displays the total amount of Medicaid payment for the claim.

Paid claims have been finalized. No additional action will be taken on them unless the provider or Medicaid requests an adjustment and makes appropriate corrections.

Managed Care Claims Paid

This section of the EOP lists all paid Managed Care claims in alphabetical order by recipient last name.

Denied Claims

This section of the EOP lists each denied claim in alphabetical order by recipient last name. An ARC/RRC appears beside each claim. Please reference the listing at the end of each EOP that defines the codes used on that EOP. For further explanation please refer to Appendix J of the provider manual.

Claims are grouped by claim type, with a total for each. A grand total of denied claims and billed amounts displays at the end of this section.

The following table lists the fields in the denied claims section from left to right, top to bottom. Not all denied claims display data in every field.

Field	*Description*
Recipient Name	Displays the recipient's last name, first name, and middle initial. Claims are displayed in alphabetical order by last name.
ICN	Displays the internal control number of the claim. Use this number when inquiring about the claim.
MRN	Displays the Medical Record Number assigned to the recipient by the provider.
PCN	Displays the Patient Control Number assigned to the recipient by the provider. This is the patient account number.
Perf Phys	Displays the provider number of the performing provider.
Recipient Medicaid ID	Displays the 13 digit recipient Medicaid ID number.
First date of service - last date of service	Displays the dates of service submitted on the claims in MMDDYY format. This displays for each line item billed, if applicable.

Field	*Description*
Procedure/Revenue/ Drug Code and Description	Displays these codes as they were submitted on the claim, with a description of the procedure code. This displays for each line item billed, if applicable.
Total Billed	Displays the amount billed on the claim. This displays for each line item billed, if applicable.
Non Allowed	Displays the amount of the billed amount that Medicaid will not cover. This displays for each line item billed, if applicable.
Total Allowed	Displays the amount of the billed amount that Medicaid will cover. In the case of a denied claim, this amount is always $0.00. This displays for each line item billed, if applicable.
Patient Liability	Effective on the first Checkwrite in October 2003 this field will no longer display on the EOP.
Other Deducted Charges	Displays the amount paid by a third party insurance. This displays for each line item billed, if applicable.
Paid Amount	Displays the amount Medicaid paid the provider for the claim. In the case of a denied claim, this amount is always $0.00. This displays for each line item billed, if applicable.
ARC/RRC Codes	Displays an Adjustment Reason Code and/or a Remittance Remarks Code about claim adjudication. This displays for each line item billed, if applicable.
DED	This field is only used for adjusted claims.
TPL	Displays the amount paid by a third party insurance.
Total Billed	Displays the total billed for all line items on the claim.
Total Non Allowed	Displays the total payment that Medicaid will not cover for all line items on the claim.
Total Allowed	Displays the total allowed amount for all line items on the claim. In the case of a denied claim, this amount is always $0.00.
Total Patient Liability	Displays the total patient liability for all line items on the claim.
Total other deductible charges	Displays the total deductible charges for all line items on the claim.
Total Paid Amount	Displays the total amount of Medicaid payment for the claim. In the case of a denied claim, this amount is always $0.00.

Denied claims are finalized. No additional action will be taken on them unless the provider makes appropriate corrections and refiles the claim. This section also includes denied adjustments.

Managed Care Claims Denied

This section of the EOP lists all denied Managed Care claims in alphabetical order by recipient last name. Medicare-Related Claims Paid

This section of the EOP lists all paid Medicare-related claims in alphabetical order by recipient last name.

Medicaid-Related Claims Denied

This section of the EOP lists all denied Medicare-related claims in alphabetical order by recipient last name.

Adjusted Claims

This section of the EOP lists adjustments made to correct payment errors in alphabetical order by recipient last name. Adjustments consist of two sections: Debit (Repaid at Higher/Same Amount) and Credit (Repaid at Lower Amount/Denied).

The ***"Debit"*** section indicates changes made to the original claim or additional amounts EDS owes the provider. It lists information in reference to the original payment, including the original claims number, the paid date, and the original paid amount. Debit adjustments are grouped together with the description Adjusted Claims: Debit (Repaid at higher or same amount). This segment lists a complete breakdown of the corrected information. The repayment is included as a part of the total paid claims amount.

"The ***"Credit"*** section lists information in reference to the original payment, including the original claim number, the paid date, and the original paid amount. Credit adjustments are grouped together with the description Adjusted Claims: Credit (Repaid at lower amount or denied). This is the amount owed to EDS that will be deducted from current explanation of payment.

This section also includes paid crossover adjustments. An ARC/RRC code is assigned to each action that has taken place in the adjustment process. An explanation of these codes is listed after the Summary Page of the EOP.

The Net Adjustment is the difference between the original paid amount ("Credit"), and the repaid claim ("Debit") financial Items.

Refunds

This section of the EOP lists, in alphabetical order by recipient last name, those claims for which the provider has sent EDS a refund check.

NOTE:

Because EDS must correct claim payment history, the full payment amount must be credited for claims paid in error before the claim can be reprocessed correctly. If the provider has sent EDS a partial refund, the difference between the payment amount and the refund amount will be credited under the "Provider Refund Checks Processed" section of the summary page.

Claims In Process

The claims in process section of the EOP lists claims currently in process for the provider, in alphabetical order by recipient last name. Claims that appear in this section are paid, denied, or suspended as appropriate on a future EOP. Providers should not submit inquiries or resubmit suspended claims as long as they appear on the EOP as suspended. If a claim appears in this section for more than two remits, please contact the EDS Provider Assistance Center to verify the status of this claim.

Summary Page

This page of the EOP is divided into two sections. The first section contains *informational data* (for example, beginning credit balance, total claims considered for payment, total claims suspended, total denied claims, and refund/void adjustments processed) for the current checkwriting period. The refund/void adjustment section displays current and year-to-date totals.

The second section contains *payment data* (for example, total claims approved for payment, claims adjusted, total net adjustments, audit adjustments, and check amount) for the current checkwriting period. Each section displays current and year-to-date totals.

NOTE:

If a credit balance has been established at the end of the payroll, the last entry appears as “Credit Balance Carried Forward,” and the following EOP lists this amount in the “Credit Balance Brought Forward” section of the payment data. The last EOP issued for the calendar year notifies providers of the amount submitted to the Internal Revenue Service for tax reporting.

ARC/RRC/CSC Codes

Following the summary page is a listing of definitions for the EOB codes used on each statement. This section also contains Adjustment codes identifying adjustments. (Refer to Appendix J of this manual for a complete list of these codes).

Encounter Data

This section of the EOP contains encounter claim data and follows the same sequence as the main part of the EOP. The encounter data is for informational purposes only and does not show any dollar amounts paid. However, the provider should resubmit any correctable denied encounter data claims for payment. The plan code identifies the payer of these claims followed by the district. Example: PXX would be a Maternity Care claim processed by the Maternity Contractor in district XX and HXX would be a PHP claim processed by district XX.

6.2 Reimbursement Schedule

Claims that have been accepted for processing either through electronic submission or manually by EDS staff are processed on a weekly basis. Payment for these claims is disbursed based on the twice a month checkwriting schedule as approved by the Alabama Medicaid Agency.

Information regarding checkwriting schedules is listed in the bimonthly publication of the Alabama Medicaid Provider Bulletin and can also be obtained on the Medicaid website at www.medicaid.alabama.gov.